Refer to: Deisher JB: What is so special about a family physician?
West J Med 121:521-529, Dec 1974

Special Article

What Is So Special About a Family Physician?

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Around a core of common, acute and chronic, recurrent health problems, a family physician must marshall the traditional episodic management for both inpatient and outpatient illness. He must also be especially adept at recently emerging routines of prevention and early detection. He provides individual and familial psychologic support and counselling, for both its therapeutic and preventive values. In addition, he must relate the individual care of his patient and the patient's family to the community as a whole. In doing this he will use not only his own skills but those of lay health volunteers, trained allied health care professionals and skilled subspecialists in the limited medical disciplines.

The proper preparation of family physicians for this complicated role has far-reaching implications for change in both medical education and medical practice.

THE CERTIFYING EXAMINATIONS of a specialty board should aim to test a candidate for his ability to perform the unique functions of that specialty. Residency training programs should provide training in those same functions. Now that the American Board of Family Practice (ABFP) has been established and accepted, the definition of family practice has an even greater practical importance than before. It is vital to define the functions of a specialist in family practice in order to assist in the planning of both the educational experience and the examinations. The first examinations of the ABFP were a "glorified Part III of the National Boards." There was little or nothing in them that should not have been answerable by a physician who has just completed a rotating internship. Is the 3-year residency in family practice meant to produce a glorified perpetual intern? Not likely.

One of the reasons why young physicians have tended so strongly to specialize in depth, rather than in breadth, has been the impossibility of becoming an expert in all specialties at a level of competence that warranted the respect of the top men in each specialty. Some physicians seem almost able to do this—but they are rare. It is futile for the family or general physician to attempt to compete in surgery with surgeons, in radiology with radiologists and so on. And yet,

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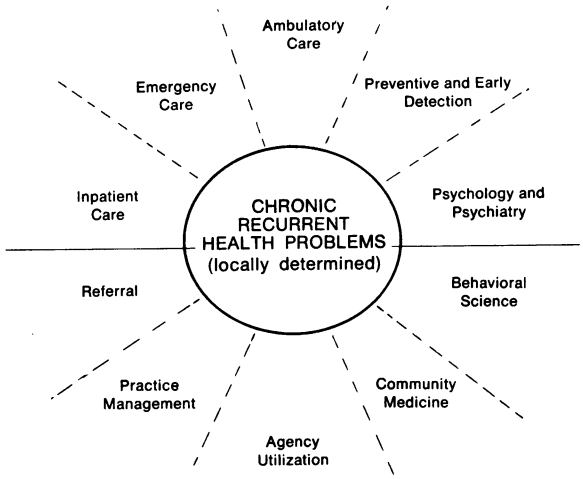

Figure 1.—Modern Family Practice. Major areas of knowledge and skill required of family physician.

no one wants to be thought a second-class doctor. In order that he may not fall into such a category, the special function of a family physician must be defined. This function is what departments of family practice must teach, and what the ABFP must examine for.

To define family practice using the traditional disease and treatment orientation is asking for second-class status when breadth of knowledge and the ability to organize family and individual health strategies are not highly valued. Such an approach leads to argument about what is and what is not a part of family practice. For example, is a dilation and curettement within the scope of family medicine—and what about first-time upper gastrointestinal bleeding? Simple cystoscopy? Reading an electrocardiogram? Reading an x-ray film of the chest? The list could go on and on.

The key to differentiating between a family physician and an old-style general practitioner lies in the assumption of a different responsibility by the family physician. The adjectives competent, continuing, comprehensive, conscientious and compassionate as applied to care have been insisted upon by the American Academy of Family Physicians since the beginning of its discussions in this field. To offer this sort of care (in place of the episodic, fragmented, one-man-24-hours-7-days-a-week type care traditionally provided by the stereotype general practitioner) requires that the new family physician have the knowledge and skills to develop a system of delivering health care which will necessarily involve many other personnel. He will be required to manage and direct a team of trained professionals, many of whom may have much more detailed knowledge than he in their specialized fields. They in turn will not have his breadth of knowledge and synthesizing skill.

Modern Family Practice

Defining the role of a specialty in health care is seldom a clear-cut matter. Mostly, it has to do with emphasis. Surgery is concerned with cutting, but there are many other essential aspects to surgery. Few argue over the relationship of these to the essential modality—the scalpel. Anesthesiology began with the relieving of pain during operations, developed an emphasis on the management of the unconscious patient and associated emergencies and, like other specialties, has a large but necessary foundation of basic medical and surgical information in support of these special functions.

There is a collection of definable skills which are specific aspects of family practice, not consignable to the catchall terms of general practice or "undifferentiated physician." Figure 1 shows the major areas of knowledge and skill required of a specialist in family practice. Of the ten segments, those above the horizontal line are largely traditional portions of medical training. They have generally, in the past, been taught with diminishing emphasis from left to right. Those below the horizontal line are the special areas of instruction in which emphasis must be added to professional education in order to produce a modern family physician.

The Focus of Family Practice

Wilson[2] identified the essence of family practice as an attitude. In truth, it is the sum of several attitudes. Together they represent an older philosophy of care which too often appears to have been lost in the busy episodic application of the miracles of modern medicine. This suggests that physicians may have forgotten the need to orient work, and therefore training, to the needs of the particular population that each physician is serving and to the local health problems they face.

For a family physician, the focus of his family practice (Figure 1) is a locally determined set of common health problems—acute, chronic or recurrent—which will be just a little different for each. The composition of medical practice and the kinds of knowledge and skills required may, in some instances, vary widely from one locale to another. Factors contributing to such differences include climate and the age, ethnic background,

local customs and degree of urbanization of the population. The training should be different for a family physician planning to practice in Homer, Alaska, than for one who will practice in Houma, Louisiana. One implication of this is that a family physician should be helped early in his training to formulate basic decisions about where he would like to practice. Will it be in an urban, suburban or rural area? In what sort of climate? Amid what sort of people? There is no denying that man proposes and God disposes, but with some general decisions of this sort, based on an analysis of himself and his intentions, he can begin to plot an appropriate course of study. As his studies progress, of course there will be a progressive sharpening of the details of that decision. Alternate goals and alternate studies will be selected which will help to meet expected functional needs more exactly.

One significant aspect of this philosophy is the patient-oriented commitment to design one's training and practice around the primary health needs of the patient community which selects one as their physician. This differs widely from the concept of restricting one's training and practice by arbitrarily selecting the health needs to be concerned with according to definitions based on anatomy, therapeutic mode, age, sex or causative agent—and accepting only those patients who fit the criteria.

The family physician must be committed also to dealing with those common illnesses of man for which there is no cure, only control—and often little of that. These diseases are mostly chronic, usually non-lethal, often progressively crippling. They are frustrating to treat because of the difficulty of resolution. Often their control depends upon the arduous process of remolding the patient's life-style, or even his personality. To be content in family practice, the physician must make an informed choice based on a thorough knowledge of himself. He must decide whether the health of his patients (promoted through low-key, persistent efforts at prevention, early detection and early treatment of common illness) will provide the professional satisfaction he requires, or whether he must have frequent infusions of the drama and anxiety and proud gratification which can come from the episodic saving of life or limb.

To many it is not enough to recommend the use of seat belts and safe-driving practices rather than deal proficiently with the injuries resulting from the traffic accident. It is more taxing to the therapist to modify the patterns of interaction within a family than to prescribe diet and antacids—and occasionally surgical procedures—for the ulcer induced by existing patterns. Satisfaction with this sort of commitment to the humbler approach requires a high level of insight, maturity and self-knowledge. A commitment to treating the chronic and recurrent common diseases implies a continuing of responsibility to the patient and the patient's problems, competence in medical knowledge, skill in human relations, and the compassion to avoid with dignity the too-frequent trap of the educated man—arrogance or hauteur.

Ambulatory Care

The topmost of the peripheral segments of Figure 1 indicates that health care by family physicians is provided predominantly to ambulatory patients. Kerr White[1] has shown that a small minority of people who have health needs are admitted to a hospital. A family physician is, to most of his patients, *the* point of access to the health care system. He is the primary physician who deals with the "vertical" patient over a horizontally broad spectrum of health activities, as opposed to the limited specialist who deals with the "horizontal" (bed) patient in a very deep and intensive manner. Skill in providing ambulatory care, then, is a major need for a family physician and his coworkers. Primary care includes two segments which may be called health care and healing care. The first comprises those activities of health and medical personnel especially related to preventive maintenance. The second aspect, healing care, applies to activities directed to those who are not well. Definitive, early diagnosis may well require astute observation, often over a period of several visits, in addition to sound medical judgment. The implication of this concept of two related kinds of care for teamwork among health professionals has great bearing on the training program in family practice.

Emergency Care

Access to care includes emergency access and ordinary, planned access for non-emergency reasons. For practical purposes we must concede that an emergency exists whenever the patient needs, or feels that he needs, immediate attention to a health-related problem. The key word is immediate. Time is of the essence in any definition of emergency. Many "emergency" patients can be

treated simply and sent home. This is particularly true when the treatment is provided by a tenured family physician who is familiar with the patient and his family. Because a fairly large percentage of emergency patients will need to be admitted to the hospital as inpatients for observation or more definitive care, a family physician must be capable of perceptive triage as well as appropriate definitive treatment in the emergency room. He must also have the privilege to admit his patients under his own care, as well as to call for consultation or referral. A family physician needs to learn enough about emergency care to manage the less complex medical emergencies of his patients and to identify the larger ones. For the latter, he must be able to provide adequate first aid preparation for transportation including cardio-pulmonary resuscitation and the management of fluid and electrolyte balance. He must be knowledgeable in arranging for care by a limited specialist in those cases where he deems it necessary, and always he must provide his personal support to the patient and to the family.

Inpatient Care

A family physician should be adept at providing inpatient care for common conditions requiring admission to hospital. He must be afforded hospital staff privileges commensurate with his training and based on personal evaluation of skills by the local staff of the hospital where he takes his patients. There is a large group of common (though serious) illnesses, including some whose best therapy is surgical, which a family physician should be capable of managing as well as and often better than the limited specialist. To many of the latter, the commonplace sometimes seems to have become so mundane as to receive less than the fullest and finest attention. The process of referral should be a well-developed skill of a family physician and he should have a well-established network of resource physicians to whom he refers his families with every confidence of good care and consistent, thoughtful "dereferral." Although the primary physician deals most often with the "vertical" patient, who is entering the health care system for a brief time, he also functions importantly in returning the patient who has been in a hospital for a longer period to (as nearly as possible) his functional vertical position in his family and community. Through active participation in inpatent care, he facilitates his management of this rehabilitation process.

Health Maintenance

The three aspects of family practice listed so far have been the only segments of family practice taught with any great emphasis in most medical schools and residency programs until recently. Disease prevention and early detection have usually received brief didactic coverage in courses on epidemiology and public health, and have proved less than exciting for most students. In contrast, methods of prevention and early detection of disease not only have become broadly feasible in modern health; they also offer the major hope for decreasing the devastating costs of medical care and hospital stays. Many of the details of prevention and early detection, since they constitute health care rather than healing care, can be performed by middle level practitioners. However, the planning and the overall reporting to the patient of the outcome of activities related to health maintenance and prevention will often require the authority of the physician.

Until recently, the technology of health maintenance has been very sparse. However, there is a growing body of knowledge concerning the early detection of a number of common illnesses which often have significant impact on a patient's life and about which something can be done if they are detected in the early stages. Information is accumulating on the correlates of subsequent illness to the extent that health hazard appraisal is now a recognized technique for encouraging patients to change life-styles and habits known to be likely to lead to ill health in the future. Screening programs have proven able to uncover more handicaps than the health care system can handle comfortably. This technology must be made part of the armamentarium of the primary physician.

Health maintenance also includes the management of minor, though annoying physical adaptive changes which are simply overactive physiological variations within the patient. In the course of skillful minor care, the detections of recurrent patterns of these minor problems may lead the astute, well-trained observer to detect a major, underlying, insidious common cause while it is still in an early and treatable phase. For example, repeated asthma in a child or young adult leads eventually to permanent lung damage and disability. Repeated bouts of peptic ulcer may produce serious complications such as obstruction, perforation or hemorrhage. Repeated bouts of temporary blood pressure elevation associated with episodes of fear or anxiety seem to be a part of the natural history

of the development of irreversible hypertension. If, through skillful management not only of the episodes but of the life-style and family setting of the patient, these antecedent episodes can be minimized, their deleterious consequences will be minimized also. Early recognition and skillful management of chronic urinary tract infections in girls has the same potential for promoting health. This sort of health maintenance activity holds perhaps the most practical promise of the whole concept of continuing care and the maintenance of continuous family records.

Psychology and Psychiatry

In the field of prevention also lie many matters of psychological evaluation and supportive psychiatry for the individual patient and for the family. Carmichael[3] estimates that a family physician, after a period lasting up to two years, acquires tenure in the family constellation of most of his patients. From this position of security and trust, he can provide insights and supportive strength in a unique way. Major intervention in the province of the psyche, however, should be dependent on demonstrated skill, just as in the more physical domains of medicine.

Out of the training for family practice must come for each student a philosophy of the nature of man and his needs. A general concept of the mechanisms of motivation is an essential part of such understanding. Equally important are recognitions of the validity of personal idiosyncrasy and the life style determination. A new family physician should be acquainted with various normal and pathological states of consciousness including sleep and its disturbances, alcohol and drug use, transference, hypnosis and meditation. He must be able to understand the ubiquity of depression and its role in the production of disease. Along with this goes an understanding of the common need for dreams and minor delusions. The non-judgmental approach, which leads to compassionate care as well as detached concern, is even more important for a family physician than for the limited specialist.

A fair degree of self-knowledge is an essential prerequisite to effective patient and family management in family practice. To help student-physicians understand the psychopathology of their own everyday life should be one of the instructional objectives of training in family practice.

Behavioral Sciences

The traditional individual psychologic and psychiatric concerns merge almost imperceptibly with the management of family problems through understanding of the social sciences. Practical ways of using the fund of social scientific knowledge have only recently been subjected to study and disciplined organization for therapeutic use. This new understanding includes a knowledge of the operation of small groups and the normal growth and development of both individuals and family units. The modern concept of the family encompasses any group of people living together more or less permanently, whether or not they have blood or legal ties. Prevention and early detection of destructive interaction in the family, and the treatment of established interpersonal problems are part of the specialty of family practice. Milieu, group and family therapy are all useful tools about which knowledge and skills must be acquired. Knowing when to refer patients and families to a social worker, psychiatrist, clergyman, lawyer or therapeutic group, and how to manage the transferral of care must be part of the training for family practice. The weaving of this sort of knowledge into the specific treatment plan for individual health and medical problems is a skill to be learned. The accommodation of treatment strategy to the various cultural patterns determines the efficiency of such treatment in terms of patient compliance with plans.

The art and science of communication is perhaps best mentioned here. Defective communication, both in sending and receiving, is perhaps the most widespread and insidious cause of problems for the individual physician, his patients and medicine as a profession today. Interviewing is a basic technique which is very important to family physicians. Here active listening is an essential in which many physicians are quite untutored but which is fundamental to effective family practice. The communicative aspects of interaction and transaction are equally basic to family and primary care.

It has become more and more obvious that there is a need for the physician and other members of the health team to be teachers. Doctor, in fact, means teacher. The goal of education is planned change of behavior. This is exactly what health maintenance is all about. An elementary knowledge of educational processes will not only allow the physician and other members of the

health team to teach patients; it will assist them in their own continuing education efforts so that they may maintain a high degree of competence throughout their careers.

Community Medicine

Once the medical perspective has enlarged from the individual to his family, the physician is already dealing in the area of group health. To deal with community medicine, he needs only to enlarge his area of concern to include the block, the neighborhood and the larger community. Community medicine is the practice of medicine with the community as the patient, and it requires the same elements of ethical responsibility, rationality and patient involvement and compliance as does the practice of any other kind of medicine. Consideration of the organ, the individual and the community as a series of interacting systems provides a universally applicable perspective for the health professional, the major variable being the degree of magnification. The patient's disease (or well-being) is so intimately related to his setting that the holistic view of one person necessitates a workable comprehension of the community. There are basic patterns of community operations, entry, politics and group influence that should be as much a part of the armamentarium of a family physician as his knowledge of cellular processes.

Understanding of the cultural patterns of his patients and their impact on what has been traditionally called public health must be an automatic consideration by a family physician in his diagnosis and planning for treatment. The relationship of civic economies, the concept of the "community of solution," and an understanding of the social foundations of professional care are essentials in the curriculum of a family physician. These and other aspects of community anatomy and physiology must form, with the traditional aspects of health career training, a matrix of consideration and understanding. The pilot examples of this sort of community action are slowly taking shape relative to the development of fully integrated and coordinated emergency medical services throughout an area, and in reference to certain environmental protection programs.

Use of Agencies

A full working knowledge of the operations and assistance offered by agencies within the community which relate to various aspects of health and helping is an important aspect of a family physician's ability to assist his patient. One of the greatest gaps in our health system today is between the patient and the very numerous agencies available to help him. These may be governmental or private, for profit or not for profit, medical or social, voluntary or professional. Unfortunately, they are most often unknown to those who need their help the most. Referral to such agencies of a quasi-medical nature should be done as skillfully and thoughtfully as a purely medical referral.

This aspect of health care management will doubtless be emphasized most in the latter phases of family medicine training but awareness from the earliest days of the interrelationship of physician and these other members of the health team is an important instructional objective. Increasing experience with such team-members-in-training seems advisable during a family physician's training years.

Practice Management

Bringing together a patient and his community resources relates closely to the whole area of practice management, operating an office and establishing relationships between the doctor's personal practicing conditions and the other health institutions and professionals. The manner of practice management determines and is determined by the patterns of referral from the family physician's office to other agencies, institutions and individual practitioners. The use of middle-level practitioners and other allied health personnel will become more common at an exponential rate as national health insurance in one form or another is enacted. The management of the team and the skillful use of each member's talents for the greatest benefit of the patient will be new and exciting challenges to the leadership ability of family physicians. The team can be expected to include administrators and other non-clinical consultants for most family practices in the near future. The spectrum of arrangements for health care delivery from solo practice to the multi-branched group, will be a vital portion of the knowledge of the family and community physician, and constitute a legitimate and badly needed area of research for academic departments of family medicine. Here again, heavy emphasis is more acceptable late in the training period but the awareness of potential need is important throughout the family medicine curriculum.

Specific training areas in the field of practice

management include the elementary principles of personnel management, financial management, simple bookkeeping, business law, business insurance and customer relations. While not taking a great deal of time for each subject area, training in family practice should supply adequate general references for future use, and a fundamental vocabulary which will permit the physician to learn, with a little practice, to skillfully guide his own affairs, as well as those of his patients. Somewhat more detail could be included about health insurance, both governmental and private, and some concepts of welfare provisions of a general nature.

Referral

For some of the major problems of care related to specific episodes, especially in the "horizontal" patient requiring admission to the hospital, a family physician will need to obtain consultation or refer the patient to a limited specialist. He should learn to do this skillfully and easily, with assurance from his colleague that the patient will be returned to him for continuing family care as soon as the critical episode has been dealt with.

Correspondence between members of the health team in referring patients for consultation and in "dereferring" patients from the consultant back to the patient's principal source of care constitute a subject which requires considerable thought and sensitivity. Abstracting the significant parts of a clinical problem in a referral note, rather than a total recall description, is a knack that more physicians should acquire.

The subject of referral has been little examined in a formal way. There are many inherent difficulties which make for friction and poor communication between members of health care teams and patients, and within the team itself. The subject called medical ethics has dealt imprecisely and inadequately with these problems in the past. The ability to listen well, and the strength to make overall managerial judgments, even those which may contravene one or another consultant, are virtues a family physician can only acquire through study and practice.

Educational Implications

Sound educational principles demand that training for a family physician be based on a clear definition of the tasks—the role—that he will assume in practice. In sum, he will be expected to design a system of delivery of health care that is custom-tailored to the needs of each of his patients. He will personally perform some of the necessary functions for entry into and exit from the system among his duties as a primary care expert. More important, perhaps, will be his ability to organize separate segments of the health care delivery resources of the community in which he chooses to practice so that they will best serve the individual needs of his patients. In the years ahead, when those presently in training will be putting that training to the test, there will be more and more emphasis on prevention—primary, secondary and tertiary. Almost equal emphasis will develop related to cost control, not only of the immediate episode of care but in reference to health planning. Family practice training today must include a liberal portion of community medicine, as well as economics and management processes.

In order to fashion the necessary personal health care plans required by his patients, a family physician will need to be fully up-to-date on medical and surgical technology and its potential, but the more esoteric details will only rarely be essential to such planning. Today's training, then, must curb the tendency of most limited specialties in faculty positions to teach ever more deeply into their subjects, and must promote the development of connecting insights which link one intensive discipline with another. The interlocking of such linkages is the special technologic subject matter of family medicine.

To perform adequately the tasks listed here will require an artistic level of skill in the sensitive management of communications between two people, among groups of people and among the several facets of the individual patient's own personality. The specialist in family medicine can no longer afford to pass so much of the burden of this sort of activity over to the nursing profession. Training—guided, reflective training—in communication processes must be a major part of the instruction in the undergraduate and graduate programs in family practice.

It seems clear that the concept of *synthesis* is the key to the mode of operation of the family physician of the future. Wilson[4] speaks of the synthesizing function of this "new specialist." This synthesizing function is one of assisting the patient in the coordinating and integrating of his personal health needs with his other needs and aspirations within the setting of his family and community. It

is the family physician who works out the overall health strategy. It is he who interdigitates the activities of the health team, as a conductor coordinates members of an orchestra. It is he who assures that both the patient and those around him understand their health and medical situation and what can be done to improve it. For instance, if a diabetic who must carefully curb his caloric intake is married to a woman whose major successes in life derive from cooking delicious, high-calorie food for those she loves, their family physician must assist them to manage the adjustment of lifestyle required to accommodate both the patient's health and his marital situation. There have been physicians who have done this under the traditional system based on traditional education, but they have been unusual. The growth of interest in and need for family physicians requires that those responsible for the medical education system design curricula to teach this sort of skill. This is the synthesis of a health related program-of-living incorporating detailed medical knowledge, intimate psychologic understanding and interactional management skills. The number of variable yet manageable factors in this sort of operation equals or exceeds those involved in the most complex medical and surgical procedures within the anatomy of one individual or a single organ.

The use of the word "synthesis" here is significant from another perspective. In educational circles, to attempt the evaluation of the ability to synthesize from one's knowledge and understanding is to work at the most difficult level of testing.[5] Synthesis is impossible to parrot—to learn by rote. It requires participation, personal expression, ingenuity and high levels of knowledge and commitment. It has been noted that testing for the art of medicine is rarely included in professional examination. Perhaps the intuition of the teacher has been that those who were ready to learn it, would assuredly pick it up; that those who were not ready, could not pick it up; that even if it were taught there was no way to articulate the content anyway, and that he could evaluate it through acquaintance and contact with the student. This will not suffice for the teaching of family medicine. We must believe that we can describe what we think. If we can recognize good family medical practice, we must dredge up the words to articulate what it is we mean by such an expression. We are obliged further to articulate these concepts so they are intelligible to others—intelligible enough so that consensus on both curricular objectives and evaluation can be achieved. As always in the process of evaluation for certification purposes, the concern here is for setting of minimums—for building a floor of assurance—relative to necessary knowledge and, we hope, to consequent performance.

The challenge to educators in family practice, then, is to train a professional who can synthesize the various factors of each patient's predicament into a continuing life-style with the highest level of potential for promoting health, and to devise ways to test his ability to do so. This is an unusual assignment. Most current educational programs heavily emphasize activities in which the student functions as consumer-and-critic of ideas, rather than producer-and-synthesizer. Synthesizing requires the organization of ideas, often in new and novel ways, always in ways tailored to a special situation, and sometimes the development of ideas that are totally original.

Perhaps the most important implications are that this is communication, that communication requires synthesis and that this whole process is art. The effective communication of even a relatively common idea to a specific person for whom it happens to be new is, in its way, a work of art. The development and conveying of a program of health care to a patient and his family in such a way as to achieve compliance (and consequent beneficial results) must be accorded the status of artistry in many cases—the art of medicine. Leonardo de Vinci described perfection in art as that construction from which nothing could be taken away and to which nothing could be added without diminishing its impact. This is a definition of elegance. It is also a definition of good medicine—especially good family medicine.

Summary

Although fulfilling needs as old as mankind, although based on a long and honorable tradition, the role of family physician and the education for it cannot, of necessity, follow the traditional pattern. Instead, it must be aimed, through use of the most up-to-date information available, toward a new sort of practice set in the future. Restriction by traditional mold would set the stage for another failure in the efforts to provide the levels of care which are often achievable but not so often available. To a degree depending only on his interest and ability, the family physician of the future will become a manager of health and health care systems; a solver of complex health problems for

the family and community and an advisor, confidant, friend and advocate after the manner assumed by many astute physicians of the past but seldom specifically prepared for in their training. The provision of a constantly available resource in time of emergency, a guide to the complexities of the health care system and an advisor on a vast array of complicated decisions of life are functions which have always been a part of family practice. In the past, however, there has been little directed training for these. Underlying these and all the other functions of a family physician must be a profound intuitive and instructed understanding of human life and its interrelations. In the past this material has seemed too complex or too simple or too intimate to be taught. We have now progressed to a stage where these things can be brought into consciousness and identified as learning objectives.

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Length of Medicare Hospital Stays by Region

MEDICARE PATIENTS in the West had significantly shorter hospital stays in 1970 than those in the Northeast for treatment of the same medical conditions, a Social Security Administration study has found.

The report, titled *"Medicare 1970: Length of Stay by Diagnosis,"* was issued by Social Security's Office of Research and Statistics. It found differences in hospital stays of up to 50 percent between the two regions.

The average length of stay nationally was shown at 12.8 days. In the Western states, the average stay was 10.1 days; in the South, 11 days; in the North Central states, 13.1 days; and in the Northeast, 15 days.

The study was based on a sample of 5.5 million discharges of Medicare patients from short-stay hospitals in 1970. The differences in length of stay between regions carried through all age groups over 65 and in cases with surgery, as well as those without surgery.

Women diagnosed in the West as having breast cancer had an average hospital stay of 11.1 days. In Northeastern hospitals, the average stay for treatment of breast cancer was 16.4 days.

Other examples of the differences in hospital stays between the two regions were:

- Arteriosclerotic heart disease: West, 9.7 days; Northeast, 15 days.
- Acute coronary occlusion: West, 13.9 days; Northeast, 18.3 days.
- Fractured femur with two or more diagnoses: West, 22 days; Northeast 29.5 days.
- Malignant neoplasms of the cervix: West, 7.5 days; Northeast, 16.5 days.

There were no major differences in length of hospital stays between the Southern and North Central states, the report showed. For example, treatment of breast cancer produced an average stay of 14.5 days in the South and 15.7 days in the North Central states. Treatment for arteriosclerotic heart disease required 11.5 days of care in the South and 13.3 days in the North Central states.

Single copies of *Medicare 1970: Length of Stay by Diagnosis* [DHEW Publication No. (SSA) 74-11704] may be obtained free from the Publications Staff, Office of Research and Statistics, Social Security Administration, 1875 Connecticut Avenue, N.W., Washington D.C. 20009. The report may be obtained in quantities through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. (Stock No. 1770-00236) at $2.40 a copy.